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HOW TO COMMUNICATE EFFECTIVELY WITH BARIATRIC PATIENTS IN THE TIMES OF GLOBESITY?

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ABSTRACT

Obesity is a condition affecting an increasing number of people worldwide, to the point where it has reached pandemic proportions - "globesity". It significantly increases the risk of other co-morbidities, including cardiovascular disease, dyslipidaemia and type 2 diabetes.

Obesity is a serious problem, not only in terms of health but also socio-economically. It is currently believed that bariatric surgery is the most effective method of treating morbid obesity and reducing the risk of associated conditions.

Some healthcare professionals harbour negative preconceptions about people with obesity, which is why it is important to train interdisciplinary medical staff in how to collaborate with bariatric patients. In bariatric surgery, this is particularly crucial as it helps to ensure the expected outcomes of the operation are achieved and leads to a significant reduction in the risk of complications.

KEYWORDS

Bariatric Surgery, Global Health, Obesity, Medical Communication, Globesity

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Introduction

Obesity is a disease affecting an increasing number of people worldwide, to the point where it has reached pandemic proportions, called by the World Health Organisation as “globesity”. A large body of research into obesity points to its multifactorial causes. Both environmental factors and individual predispositions influence the occurrence of different types of obesity [1,2]. Some studies also point to the crucial role of the gut microbiota and the changes that occur within it, establishing a causal link between environmental factors and the onset of obesity; it is impossible not to mention the factors related to healthcare, on which we will focus in this paper. According to data from the World Health Organisation (WHO), in 2022, 43 per cent of adults worldwide were overweight, and 16 per cent suffered from obesity [2,3,4].

Obesity and Healthcare Around the World

A total of 14,502 people with obesity (PwO) and 2,785 healthcare professionals (HCPs) completed the questionnaire “attitudes towards obesity”. The majority of people with obesity (68%) and healthcare professionals (88%) agreed that obesity is a disease. However, 81% of people with obesity attributed their weight loss success solely to themselves, and only 44% of healthcare professionals agreed that genetics constitute a barrier. There was a median of three (mean, six) years between the time an individual with obesity began struggling with being overweight or obese and when they discussed their weight with a doctor. Many individuals with obesity were concerned about the impact of being overweight on their health (46%) and were motivated to lose weight (48%). The majority of PwO (68%) would like their HCP to initiate a conversation about weight, and only 3% would be offended by such a conversation. Among healthcare professionals, there was a belief that: a lack of interest or motivation on the part of patients to manage their weight may act as a barrier to discussions about weight management. During these discussions, healthcare professionals typically recommended lifestyle changes. However, more referrals and follow-up appointments are needed [1,5].

The indications for surgical treatment of morbid obesity are:

1. A body mass index (BMI) of 40 kg/m² or higher;
2. A body mass index (BMI) in the range of 35–40 kg/m² in patients for whom surgically induced weight loss may bring about a potential improvement in obesity-related conditions, such as:
 - type 2 diabetes;
 - hypertension;
 - cardiovascular diseases;
 - sleep apnoea syndrome, obesity-related hypoventilation syndrome;
 - joint diseases requiring surgical treatment;
 - non-alcoholic steatohepatitis (NASH), non-alcoholic fatty liver disease (NAFLD);
 - hyperlipidaemia;
 - female infertility, including that associated with polycystic ovary syndrome;
 - significant social or psychological indications;
 - situations where obesity is a reason for exclusion from a significant form of surgical treatment in other specialities (e.g. orthopaedic procedures, neurosurgical procedures, hernia surgery).
3. Surgical treatment for obesity may also be considered in patients with a BMI of 30.0–34.9 kg/m² and type 2 diabetes, where hyperglycaemia persists despite the use of oral medication and insulin;
4. Patients who have previously undergone bariatric surgery but have not achieved the desired therapeutic outcome (whether in terms of weight loss or the resolution of obesity-related conditions) should be offered revision surgery [6,7,8].

The BMI criterion refers to the highest documented value of this index in the patient’s history. Weight loss prior to surgery resulting in a BMI below the values listed above does not constitute a contraindication to surgical treatment. The absence of documented attempts at weight loss prior to planned surgical treatment using conservative methods does not constitute a contraindication to surgery in adults [6,9].

Bariatric and metabolic procedures are recommended for patients aged between 18 and 65. In selected cases involving patients with morbid obesity who are over 65 years of age, eligibility for bariatric surgery may

be considered. A prerequisite for treatment in this age group is that the patient's general health and biological age do not significantly increase the risks associated with surgical treatment. In elderly patients, the benefits of surgical treatment must outweigh the risks associated with the procedure. It should be emphasised that bariatric surgery in this age group primarily contributes to an improvement in quality of life, whilst its impact on prolonging life and resolving obesity-related conditions is significantly less pronounced [7,10].

The assessment and preparation of a patient for surgery should be carried out by a multidisciplinary team comprising specialists from various fields. The aim of the team's work is to prepare patients for surgical treatment and to oversee a safe and uncomplicated weight-loss process, both in the early and long-term post-operative periods. A key role within the multidisciplinary team is played by the coordinator, who oversees the preparation for surgery and the entire treatment process. This should be a doctor with experience in the treatment and care of patients with morbid obesity, ideally a bariatric surgeon [8,9,11].

Interdisciplinary Aspects of Effective Communication

The best outcomes from bariatric treatment are achieved when the multidisciplinary team comprises the following specialists:

- a general practitioner;
- a surgeon;
- an anaesthetist;
- a dietitian;
- a psychologist/psychiatrist;
- a nurse/social worker.

There is currently no basis for establishing uniform eligibility criteria for specific bariatric procedures. The surgical treatments for obesity currently available differ in terms of their mechanisms of action, expected outcomes in terms of bariatric and metabolic effects, as well as the range of potential complications and aspects of long-term care. The choice of the optimal method should be tailored to each individual patient and should take into account the primary treatment objective (bariatric effect / metabolic effect). The expected impact on improving metabolic status, better control or remission of diabetes, the degree of weight loss and its durability increases in the following order: AGB, laparoscopic SG (LSG), laparoscopic RYGB (LRYGB), BPD-DS, BPD. The technical difficulty of the surgical procedure, the risk of developing perioperative complications and the risk of malabsorption also increase in this order [6,8,12].

Communication between the bariatric surgeon and the obese patient is very important, as it influences patients' expectations regarding the operation, the aim of the procedure and their understanding of how the procedure is carried out. The presence of certain psychological conditions in bariatric patients means that the surgeon must be able to communicate to the patient the need for motivation and for maintaining healthy lifestyle habits. Obesity remains a socially stigmatised condition, often associated with feelings of guilt. Terms such as 'obesity', 'fat' or 'obese person' carry negative connotations for a significant proportion of patients, who prefer to refer to their condition using terms such as 'weight problems', 'unhealthy body weight' or 'unhealthy body mass index'. The terms used to refer to obesity during a medical consultation do matter [13,14].

Patients' expectations regarding weight loss following surgery are often higher than what can be achieved through bariatric surgery. This leads to patient disappointment, reducing adherence to dietary and behavioural programmes. For this reason, it is easier from the outset to set realistic goals, based on the surgeon's experience, the patient's individual characteristics and existing research. Many patients ask how many kilograms they should lose within a specific timeframe. It is important to emphasise that the weight loss process depends on many factors and not to focus the patient's attention solely on weight loss itself. The aim of bariatric surgeons should be to ensure that patients understand, at this stage, that surgery is merely a starting point to help them lose weight, provided they are able to maintain certain behaviours. Positive reinforcement is recommended to help patients adopt healthy habits, with an emphasis on improving quality of life and reducing the incidence of comorbidities [11,14,15,16].

Conclusions

A patient who has not achieved adequate weight loss or who is showing a gradual increase in body weight should be made aware of the possible causes of this situation from the outset. In particular: failure to adapt to lifestyle changes; taking medication that may have contributed to weight gain; the development of maladaptive eating behaviours; or surgical technique failure. Regardless of the cause, the situation must not be addressed in an accusatory or punitive manner; at the same time, a request should be made for a new assessment of the patient's condition by specialists in nutrition and psychiatry. Maintaining a positive and encouraging attitude towards the problem is consistent with both the patient and the surgeon taking responsibility [11,12,17].

Sociopsychological aspects should be taken into account when designing systemic solutions aimed at early identification and treatment, including through lifestyle changes for people with obesity [18]. Effective communication skills in combination with Evidence-based-medicine concepts created by interdisciplinary clinical teams are the best answer for global challenges associated with obesity issues.

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